STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155701	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/22/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 720 E DUSTMAN RD BLUFFTON, IN 46714	

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 15, 16, 17, 20, 21 and 22, 2014 Facility number: 000576 Provider number: 155701 AIM number: 100267760 Survey team: Virginia Terveer, RN, Team Leader Sue Brooker, RD Martha Saull, RN Julie Call, RN (10/15, 10/16 2014) Census Bed Type: SNF: 1 SNF/NF: 62 Residential: 29 Total: 92 Census Payor Type: Medicare: 2 Medicaid: 30 Other: 60 Total: 92 Residential Sample: 7	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings in accordance with 410 IAC 16.2-3.1. Quality review completed on October 27, 2014 by Randy Fry RN.			
F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observations, interview and record review the facility failed to provide activities as care planned for 1 of 1 resident reviewed for activities (Resident #47). Findings include: Review of the clinical record for Resident #47 on 10/21/14 at 10:28 a.m., indicated the following: diagnoses included, but were not limited to, Alzheimer's disease, depressive disorder, anxiety state, obsessive compulsive disorder, and macular degeneration. An Activity Progress Note for Resident	F000248	F248 All residents have been identified for the potential to beaffected. For the resident identifiedduring the survey the following actions have been taken: Her care plan was updated on 10/22/14 to reflect necessary changes. The recliner in the ActivityRoom has now been moved to face the television. CNAs, however, have been asked to place the resident in a commons arearecliner, when available, so she is in the common area as much as possible. Theactivity table in the commons area has been exchanged with a smaller one toonly accommodate 2 residents so that no one will be facing the wall or havetheir back to the common area. Nursing staff has	11/07/2014

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	#47, dated 1/30/14, indicated she sat in the commons area throughout the morning and was put to bed for an afternoon nap most days. The note also indicated she no longer made any type of activity decision, but would smile when spoken to and seemed to enjoy watching the activity going on around her. The note further indicated she sometimes held onto a doll baby or would flip through a magazine or rip up a newspaper when set in front of her. The note also indicated she had been taken off of the psychosocial care plan as she seemed to be very content and well-adjusted in the Orchard area. An Activity Progress Note for Resident #47, dated 4/24/14, indicated she sat in the commons area or in the activity room recliner in the morning and was put to bed in the afternoon for a nap. The note also indicated she no longer participated in group activities and did not make her own activity decision. The note further indicated she would smile when spoken to and would fiddle with objects on the activity table in the commons area. The note also indicated she would hold a stuffed animal occasionally or liked to pick at a blanket or an old telephone that was on the table. An Activity Progress Note for Resident		also been instructed to give the residentsomething to hold, look at, or “fiddle” with while sitting in the activity roomor commons area. If the resident is put in the Activity Room recliner, staff isto put something appropriate, such as a video or television program, includingthe music channel, on the television. Wewill also give her something tactile to hold on to. In order to stay in compliance, we will hold aninterdisciplinary weekly care plan review meeting. This meeting will be ongoing. Therefore each resident’s care plan will bereviewed quarterly.	

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	#47, dated 7/17/14, indicated she usually napped in the activity room recliner during the morning hours and would nap in her bed in the afternoon. The note also indicated she would be in the commons area during the other times and would watch what was going on around her. The note further indicated she would sometimes fiddle with the things on the activity table. An Activity Progress Note for Resident #47, dated 10/9/14, indicated she was only passive in group activities and no longer made activity decisions, but would sit in the common area and watch what was going on. The note also indicate she would at times take a nap in the activity room recliner. The note further indicated she enjoyed when people would stop and talk to her and also liked to fiddle with things on the activity area table when she was sitting there. During an observation on 10/16/14 the following was observed: - At 10:00 a.m., Resident #47 was observed seated in a recliner with her legs elevated at the far end of the activity room. Only her lower legs were visible from the doorway. There were no staff or other residents present in the room. A television and radio were present in the			

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	activity room, but neither were on. From the position of the recliner, Resident #47 would not be able to see the television as it was above and behind her right shoulder. - At 10:30 a.m., Certified Nursing Assistant (CNA) #5 and CNA #6 were observed to assist Resident #47 up from the recliner and escort her to the bathroom. At 10:40 a.m., the same CNAs walked her from the bathroom and assisted her to sit in her wheelchair. Her wheelchair was then placed at a small table next to the wall on the outside of the common area. The only item on the activity table was an old electric typewriter which was not close enough for Resident #47 to reach. - At 2:00 p.m., Resident #47 was observed resting in her bed in her room. During an observation on 10/17/14 the following was observed: - At 8:40 a.m., Resident #47 was observed seated in a recliner with her legs elevated at the far end of the activity room. Only her lower legs were visible from the doorway. There were no staff or other residents present in the room. A television and radio were present in the activity room, but neither were on. From			

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	the position of the recliner, Resident #47 would not be able to see the television as it was above and behind her right shoulder. - At 9:00 a.m., the Administrator entered the activity room to speak with the surveyor and then walked over to Resident #47 to say hello. - At 9:10 a.m., facility staff began bringing residents into the activity room for a scheduled activity, but did not approach Resident #47 or ask her if she wanted to participate in the activity. During the continuous hour of observation she was seated in the lounge chair, Resident #47 was observed to sit upright in the chair and eventually return to a reclining position. She was also observed to continually pull at her slacks. - At 10:45 a.m., Resident #47 was observed seated in her wheelchair at the table next to the wall on the outside of the common area. The placement of her wheelchair at the table resulted in her facing the wall. She could not see the other residents or staff in the common area since they were at her back. The only item on the activity table was an old electric typewriter which was not close enough for Resident #47 to reach.			

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	During an observation on 10/20/14 the following was observed: - At 8:15 a.m., Resident #47 was observed seated in a recliner with her legs elevated at the far end of the activity room. Only her lower legs were visible from the doorway. There were no staff or other residents present in the room. A television and radio were present in the activity room, but neither were on. From the position of the recliner, Resident #47 would not be able to see the television as it was above and behind her right shoulder. - At 10:38 a.m., Resident #47 was observed seated in her wheelchair at a small table next to the wall on the outside of the common area. She was not provided with anything to hold in her hands or any activity to do. - At 11:19 a.m., Resident #47 remained seated in her wheelchair at a small table next to the wall on the outside of the common area. The only item on the activity table was an old electric typewriter which was not close enough for Resident #47 to reach. - At 1:45 p.m., Resident #47 was observed resting in her bed in her room.			

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	During an observation on 10/21/14 the following was observed: - At 7:50 a.m., Resident #47 was observed seated in a recliner with her legs elevated at the far end of the activity room. Only her lower legs were visible from the doorway. There were no staff or other residents present in the room. A television and radio were present in the activity room, but neither were on. From the position of the recliner, Resident #47 would not be able to see the television as it was above and behind her right shoulder. - At 10:00 a.m., CNA #7 and CNA #8 were observed to assist Resident #47 up from the recliner and escort her to the bathroom. At 10:10 a.m., the same CNAs walked her from the bathroom and assisted her to sit in her wheelchair. Her wheelchair was then placed at a small table next to the wall on the outside of the common area. The placement of her wheelchair at the table resulted in her facing the wall. She could not see the other residents or staff in the common area since they were at her back. The only item on the activity table was an old electric typewriter which was not close enough for Resident #47 to reach.			

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	CNA #3, was interviewed on 10/21/14 at 2:10 p.m. During the interview she indicated care plans described the care each resident required. The Administrator and Director of Nursing were interviewed on 10/21/14 at 4:08 p.m. During the interview they indicated care plans were to be followed. A facility care plan for Resident #47, with a review date of 10/14/14, indicated the problem area of activities. Approaches to the problem included, but were not limited to, offer resident something to hold while she is sitting at the activity table in common such as baby clothes, a blanket, magazine, or a bean bag, offer her a knotted comforter to look at and feel, try to get her to rest in the activity room, turn television to animal planet, put music on for her to listen to, and make verbal contact with her daily. 3.1-33(a)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to follow	F000282	F282 All residents have been identified for the potential to be affected. The CNA assignment	11/07/2014

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	physician orders for pressure relieving boots and failed to follow the care plan for no shoes for 1 of 4 residents (Resident #57) who met the criteria for pressure ulcers. The facility also failed to follow the care plan for a call light for 1 resident (Resident #47). Findings include: 1. Review of the clinical record for Resident #57 on 10/17/14 at 8:44 a.m., indicated the following: diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus, congestive heart disease, atrial fibrillation, peripheral vascular disease, and chronic airway obstruction. A Braden scale for Resident #57, dated 7/23/14, indicated he was at risk for skin breakdown. A physician's order for Resident #57, dated 8/20/14, indicated to obtain pressure off-loading boots for bilateral heels due to pressure blisters to bilateral heels. A Skin Assessment for Resident #57, dated 9/5/14, indicated heel lift boots while in bed or in recliner. A Certified Nursing Assistant (CNA)		sheet was updated on 10/22/14 to reflect specific care for the targeted resident (#57). CNA assignment sheets will be reviewed quarterly and as needed to make sure that the assignment sheets are up to date on all residents. Skin care plan updated on 10/22/14 for this targeted resident (#57). Care plan updated on second targeted resident (#47) on 10/22/14. Care plans for all residents to be reviewed quarterly and as needed by care plan team to make sure that care plans are up to date, are being followed, and are reflecting continuity of care in all disciplines. Nursing “to do” list updated on 10/23/14 regarding heel/feet care for targeted resident (#57). Nursing staff instructed regarding specific skin and wound interventions for this targeted resident (#57) as well as educated on following physician orders and care plans for all residents. In order to stay in compliance, we will hold an interdisciplinary weekly meeting to review care plans and CNA assignment sheets. This meeting will be ongoing Therefore, each resident will be reviewed quarterly and as needed. Please see following attachments: Exhibit A, Exhibit A-2, and Exhibit A-3	

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	Assignment Sheet for all 3 shifts for Resident #57, provided by the Assistant Director of Nursing on 10/20/14 at 3:35 p.m., did not indicate heel lift boots while in bed or recliner. During an observation on 10/20/14 at 9:12 a.m., Resident #57 was observed resting in his easy chair with his feet elevated. He was observed to be wearing his shoes and not the heel lift boots as ordered. During an observation on 10/20/14 at 3:00 p.m., Resident #57 was observed resting in his easy chair with his feet elevated. He was observed to be wearing his shoes and not the heel lift boots as ordered. The Director of Nursing was interviewed on 10/21/14 at 8:36 a.m. During the interview she indicated the staff were to make sure his heels were floated off the foot rest of his chair. A Skin Assessment for Resident #57, dated 8/13/14, indicated intact fluid filled blisters to his bilateral heels. The assessment also indicated no shoes, to wear gripper socks. A Skin Assessment for Resident #57, dated 9/5/14, indicated no shoes, to wear			

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	gripper socks. A CNA Assignment Sheet for all 3 shifts for Resident #57, provided by the Assistant Director of Nursing on 10/20/14 at 3:35 p.m., did not indicate he was only to wear slipper socks and not shoes. Resident #57 was interviewed on 10/15/14 at 3:45 p.m. During the interview he was observed to be wearing his shoes. During an observation on 10/17/14 at 10:20 a.m., Resident #57 was observed riding an exercise bike in the therapy room. He was observed wearing his shoes. During an observation on 10/20/14 at 9:56 a.m., Resident #57 was observed riding an exercise bike in the therapy room. He was observed wearing his shoes. During an observation on 10/20/14 at 12:00 p.m., Resident #57 was observed seated in a chair near the entry into the facility. He was observed wearing his shoes. During an observation on 10/20/14 at 1:05 p.m., Resident #57 was observed			

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	visiting with a family member in his room. He was observed wearing his shoes. A facility care plan for Resident #57, dated 8/13/14, indicated the problem area of impaired skin integrity on bilateral heels. Approaches to the problem included, but were not limited to, no shoes, wear gripper socks, and heel lift boots while in bed or recliner. 2. Review of the clinical record for Resident #47 on 10/21/14 at 10:28 a.m., indicated the following: diagnoses included, but were not limited to, Alzheimer's disease, depressive disorder, anxiety state, obsessive compulsive disorder, and macular degeneration. During an observation on 10/16/14 the following was observed: - At 10:00 a.m., Resident #47 was observed seated in a recliner with her legs elevated at the far end of the activity room. Only her lower legs were visible from the doorway. There were no staff or other residents present in the room. There was no call light for Resident #47 to use. During an observation on 10/17/14 the following was observed:			

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	- At 8:40 a.m., Resident #47 was observed seated in a recliner with her legs elevated at the far end of the activity room. Only her lower legs were visible from the doorway. There were no staff or other residents present in the room. There was no call light for Resident #47 to use. During an observation on 10/20/14 the following was observed: - At 8:15 a.m., Resident #47 was observed seated in a recliner with her legs elevated at the far end of the activity room. Only her lower legs were visible from the doorway. There were no staff or other residents present in the room. There was no call light for Resident #47 to use. During an observation on 10/21/14 the following was observed: - At 7:50 a.m., Resident #47 was observed seated in a recliner with her legs elevated at the far end of the activity room. Only her lower legs were visible from the doorway. There were no staff or other residents present in the room. There was no call light for Resident #47 to use.			

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	A facility care plan for Resident #47, with a review date of 10/14/14, indicated the problem area of self care deficit. Approaches to the problem included, but were not limited to, call button in reach. A facility care plan for Resident #47, with a review date of 10/14/14, indicated the problem area of alteration in vision. Approaches to the problem included, but were not limited to, keep call button in reach. CNA #3, was interviewed on 10/21/14 at 2:10 p.m. During the interview she indicated CNA assignment sheets and care plans described the care each resident required. The Administrator and Director of Nursing were interviewed on 10/21/14 at 4:08 p.m. During the interview they indicated physician orders and care plans were to be followed. 3.1-35(g)(2)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review,	F000323	F323 All residents have been	11/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155701	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/22/2014
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	the facility failed to ensure a resident with a history of falls and with use of fall prevention alarms had the alarm answered in a timely manner to prevent falls and/or was not left unattended in the bathroom which resulted in a fall for 1 of 3 residents reviewed for falls. (Resident # 45) Findings include: On 10/16/14 at 10 a.m. the clinical record of Resident #45 was reviewed. Diagnoses included, but were not limited to, the following: Dementia, Alzheimer's Disease, Osteoporosis and Transient Ischemic Attacks. The Minimum Data Set (MDS) Assessment dated 4/10/14 included, but was not limited to, the following: moderately impaired cognition and supervision required for transfers and ambulation. The MDS dated 6/3/14 and 8/3/14 included, but was not limited to, the following: severe cognitive impairment and extensive assistance required for transferring and ambulation. On 10/20/14 at 1:40 p.m. the Director of Nursing (DON) was interviewed. At the time, she also provided fall risk assessments and fall investigations which were reviewed. The fall risk assessment dated 4/4/14 indicated the resident was		identified for the potential to be affected. For the targeted resident(#45) and the other residents that had bed/chair alarms in place direct care staff was instructed on expectations and proper procedures of bed alarms on 10/21/14and 10/22/14. Facility staff educated on falls and the need for a quick response to bed alarms on 10/23/14. Fall and bed alarm in-service provided to all facility staff on 10/30/14. New bed/chair alarm policy implemented and posted on 11/6/14. Additional fall and bed alarm in-service scheduled for 11/18/14. In order to stay in compliance, we will conduct random audits on all shifts to ensure the bed alarm is responded to in a timely manner. Weekly for the first month then monthly if there are no issues for at least 6 months. These audits will be reviewed at the QAPI committee meeting for at least 6 months and as needed. Please see following attachments: Exhibit A, Exhibit A-2, Exhibit A-3, Exhibit B, and Exhibit C	

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	"not at high risk" for falling. She indicated the following: the resident had been admitted to the Dementia unit on 4/17/13 and his first fall in 2014 was on 5/24/14. From 5/24/14 to 9/20/14 the resident had 5 falls. On 5/24/14, the resident had fallen while walking in his room, which resulted in a fractured hip. He was in the hospital from 5/24/14 - 5/27/14. The DON indicated that on 5/28/14, they added a pressure pad alarm to the resident's bed due to him wanting to get out of bed. She indicated at the time the resident was ambulating with a walker and was a 1 person assist with ambulation. She indicated the second fall was on 6/27/14 at 5:40 a.m. The fall investigation report indicated the following: the bed alarm and call light were on, resident found by day shift CNA (certified nursing assistant), sitting on buttocks on floor, beside the bed; "Res (Resident) stated, "I had been up to toilet. I didn't take my walker and I tripped on my way back to bed." Res was facing head of bed as if he was heading back to bed. The DON indicated the CNA "didn't get to the resident in time" in response to the alarm to prevent a fall. She also indicated the new intervention put into place after this fall was "frequent checks." She indicated the "frequent			

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	checks" meant for the CNAs to "round on the resident more frequently." She indicated the "frequent checks" did not indicate a specific time frame "just check the resident more frequently." The DON indicated the resident's third fall was on 7/28/14. The resident's roommate's wife notified staff the resident had fallen and hit his head. The fall investigation dated 7/28/14 indicated the chair and bed alarm was in the recliner but neither were sounding. "Once the resident was back, alarm appeared to be sounding fine." The DON indicated the resident had gotten up in his room without assistance. She indicated it appeared the alarms weren't working but when staff tested the alarms after the fall, "they were working fine." She indicated the new intervention after this fall was to make sure that staff tested the alarms prior to leaving the room. The DON indicated the resident's fourth fall was on 8/9/14. She indicated the resident had been ambulating with staff and the resident "swayed and lost his balance" and staff lowered him to the floor. The DON indicated the resident's fifth fall was on 9/20/14. The fall investigation included, but was not			

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	limited to, the following: at 10:28 p.m. "(name of roommate's wife) notified writer that resident was in bathroom for a long time and she went to check and heard a thump and thinks the resident fell in the BR (bathroom)...writer went...spoke to resident and asked if he fell...resident stated yes...resident asked if he hit his head and resident stated I did and pointed to parietal region...staff interview:...I was helping another resident and had to leave resident for a minute...Teaching done: instructed staff on: not leaving resident unattended in bathroom..." At the time, the DON indicated the intervention for this fall was to not leave the resident alone in bathroom. She indicated the staff had taken the resident to the bathroom and left him alone to go answer another call light. The DON indicated a resident with an alarm should not have been left alone in the bathroom. A plan of care, dated 9/20/14 addressed the problem of "Potential for trauma-falls" r/t (related to) (5/30/14) history of falls and recent hip fx (fracture); (6/4/14) side effects of antidepressant and anxiety med (medication) and recent hip fracture repair; (8/9/14) impaired balance, decreased mobility, poor leg control, poor short term memory, fall in recent past,			

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	unsteady gait, use of devices for walking and refusal to wait for assistance. Approaches included, but were not limited to, the following: encourage to ask for assistance; call button in reach; bed alarm (5/28/14); bed/chair alarm (6/5/14); gait belt with ambulation and frequent checks (6/27/14). On 10/17/14 at 10 a.m. the DON provided current copies of the facility CNA Assignment sheets for all three shifts on the Dementia Unit. They included but were not limited to, the following for Resident #45: "bed alarm functioning properly...chair alarm while in wc (wheelchair) or in recliner in core area (common area on unit); frequent checks..." On 10/20/14 at 4 p.m. the DON provided a current copy of the facility policy and procedure for "Fall Risk Protocol", dated 12/2011. This policy included but was not limited to, the following: "The Director of Nursing reviews all incident reports after the follow-up documentation is completed and maintains a monthly log...The data from the incident is reviewed at monthly Quality Assurance meetings and also weekly falls meetings for discussion...Information from the Fall Assessment is incorporated into the resident's care plan...All staff is			

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	continuously alerted to residents at risk and care plans are modified to prevent as many falls as possible." 3.1-45(a)(2)			
F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to initiate additional dietary interventions for weight loss for 1 of 10 residents who met the criteria for weight loss. (Resident #40). Findings include: Review of the clinical record for Resident #40 on 10/20/14 at 2:16 p.m., indicated the following: diagnoses included, but were not limited to, coronary artery disease, hypertension, depressive disorder, unsocial aggressive behavior, and delusional disorder. Facility weights for Resident #40	F000325	F325 All residents have been identified for the potential to be affected. For this targeted resident(#40) the Unit Manager was instructed on 10/21/14 in regards to more effective and clearer documentation. On 10/22/14 the RD, CDM, DON, and Admin discussed measures that needed to be implemented for this targeted resident (#40) and for all other residents if a resident or family declined dietary recommendations. A “supplement between meals” button was added to ECS on 10/22/14. Family education provided for this targeted resident (#40) on 10/22/14, in which family chose to stop all current supplements. Re-educated staff	11/07/2014

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	indicated the following: 110.5 pounds on 3/24/14 110.4 pounds on 4/28/14 101 pounds on 7/7/14 100.3 pounds on 7/14/14 101.6 pounds on 7/21/14 99.6 pounds on 7/28/14 98.2 pounds on 8/18/14 99.9 pounds on 8/25/14 99 pounds on 9/22/14. Physician orders for Resident #40 indicated she received a Regular Diet (started on 3/26/12), super cereal at breakfast due to loss of appetite (started on 7/23/12), and supplement of choice at all meals (started on 9/30/13). A Minimum Data Set assessment for Resident #40 indicated she was not able to complete the Brief Interview for Mental Status. A Dietary Note for Resident #40, dated 12/11/13, indicated a current weight of 114 pounds, with no significant weight change. Her BMI (Body Mass Index) was 19.5, with a normal range of 18.5-24.9. The note also indicated she received a Regular diet with super cereal and supplements. The note further indicated her variable intake and the diagnosis of dementia and depression increased the potential for weight		on 10/30/14 to document and take credit for all intakes given to this resident (#40). On 11/4/14 3 snack buttons in ECS clarified to indicate AM, afternoon, and PM snacks. Through research, studies have found that residents that have dementia gained weight when eating from a red plate. A red plate was implemented on this targeted resident (#40) on 11/6/14.NAR policy updated 11/6/14. In order to stay in compliance, we have updated our NAR policy and instructed the NAR team members to follow up on all recommendations. This will be discussed for at least 6 months at our QAPI meetings Please see the following attachments: Exhibit A, Exhibit A-2, Exhibit A-3, and Exhibit D	

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	changes. A Dietary Note for Resident #40, dated 3/5/14, indicated a weight of 113 pounds, with no significant weight changes. The note also indicated she remained on a Regular diet with super cereal and supplement of choice with meals. The note further indicated her intakes continued to vary. A Dietary Note for Resident #40, dated 5/28/14, indicated a weight of 104 pounds, a loss of 6.2% in 30 days and a loss of 8.5% loss in 90 days. Her BMI was noted as 17.8, with a BMI below 18.5 as underweight. The note also indicated she remained on a Regular diet with super cereal and supplements with meals. The note further indicated her meal intake remained variable and her supplement intake varied from 0-100%. The note also indicated weekly weights were requested. The note did not recommend any dietary interventions be added to prevent additional weight loss. A Nursing Note for Resident #40, dated 5/30/14, indicated the family was notified of her 6.2% weight loss in the last 30 days. The note also indicated the family did not want any prescribed supplement. A Nursing Note for Resident #40, dated			

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	6/27/14, indicated the family was aware the resident was receiving supplements. The note also indicated the family said the supplements she was receiving were fine, but did not want her to receive Ensure or 2 Cal (nutritional supplements). A Dietary Note for Resident #40, dated 7/9/14, indicated a weight of 101.9 pounds, a loss of 7.8% in 90 days and a loss of 10.9% in 180 days. The note also indicated she remained on a Regular diet with super cereal at breakfast and supplement of choice at meals. The note further indicated her intakes remained variable even with encouragement. The note recommended 2 Cal be initiated. A Nursing Note for Resident #40, dated 7/14/14, indicated the family was notified of the RD recommendation for 2 Cal 90 cc (cubic centimeters) BID (twice a day). The note also indicated education on the 2 Cal was provided to the family and the family declined the 2 Cal, stating they did not want a supplement for their loved one. A Dietary Note for Resident #40, dated 8/20/14, indicated a weight of 98 pounds, a loss of 9% in 90 days and a loss of 10% in 180 days. Her BMI was noted as 16.9. The note also indicated she remained on			

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	a Regular diet with super cereal at breakfast and supplement with meals. The note further indicated her intake remained variable and she remained at risk for weight change. The note did not indicate if the 2 Cal was initiated. A Dietary Note for Resident #40, dated 9/10/14, indicated a weight of 99.9 pounds, a loss of 11.7% in 180 days. The note also indicated she continued on a Regular diet with super cereal with breakfast and supplement of choice with meals. Her appetite remained variable. The note further indicated the family did not want the 2 Cal per nurse's notes of 7/14/14. The note did not recommend any additional dietary interventions be added since the family did not approve of the implementation of the 2 Cal. A Dietary Note for Resident #40, dated 10/15/14, indicated a weight of 99 pounds, a loss of 10.4% in 180 days. The note also indicated she continued on a Regular diet with super cereal at breakfast and supplement of choice with meals. The note further indicated her appetite remained variable. The Certified Dietary Manager (CDM) was interviewed on 10/21/14 at 8:23 a.m. During the interview she indicated the facility kitchen could provide the high			

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	calorie foods of super cereal, power potatoes, super shake, and Magic cups. The CDM was interviewed on 10/21/14 at 12:30 p.m. During the interview she indicated a supplement with meals could be anything from Boost Breeze drink, super shakes, Magic Cup, yogurt, cheese, cottage cheese, peanut butter or anything else high in nutrition the resident would eat or drink. She also indicated Resident #40 particularly enjoyed drinking Boost Breeze and super shakes. The Director of Nursing was interviewed on 10/22/14 at 9:15 a.m. During the interview she indicated there was no clear documentation in the clinical record the family of Resident #40 was okay with the supplements the facility provided, but did not want any prescribed supplements added. The CDM was interviewed on 10/22/14 at 12:40 p.m. During the interview she indicated the kitchen could provide any supplement to residents that were in-house, including Boost Breeze, Magic Cups, and super shakes. She also indicated the 2 Cal required a physician's order. A facility care plan for Resident #40, dated 7/3/14, indicated the problem area			

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	of resident at risk for weight changes and dehydration related to diagnosis of dementia, depression, and variable intakes. Approaches to the problem included, but were not limited to, weight as ordered, assure adequate assistance at mealtime, offer substitutions as needed, offer snacks, offer high calorie supplement of choice with meals, and provide diet as ordered. A current undated facility policy "NAR Policy", provided by the Director of Nursing on 10/22/14 at 9:22 a.m., indicated "...To ensure that the care of the residents on the NAR (nutrition at risk) list for the current period are discussed at the weekly meeting...Discussion of weights...will be addressed each week...Monthly weights will be checked...Weekly weights will be updated and discussed...." 3.1-46(a)(1)			
F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to protect juice served to	F000371	F371 All resident were identified for the potential to be affected.	11/07/2014

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	residents during snack time from potential contamination in the common area, Plum Tree hall, and Cherry Tree hall, potentially affecting 49 of 63 residents. Findings include: 1. During an observation on 10/16/14 the following was observed: - At 10:20 a.m., a facility volunteer was observed pushing an open tiered snack cart through Cherry Tree hall. The top tier of the open cart contained a bag of cookies, a covered plastic pitcher of lemonade, and opened 46 ounce plastic bottles of apple juice and cranberry juice. The top tier also contained 4 pre-poured plastic glasses of apple juice. The lids were not placed back onto the plastic bottles of apple juice and cranberry juice and the plastic glasses of apple juice were left un-covered as the snack cart was pushed from room to room in Cherry Tree hall. - At 10:45 a.m., the same open tiered snack cart was pushed into the hallway next to the common area with the 46 ounce plastic bottles of apple juice and cranberry juice opened as well as 3 pre-poured plastic glasses of apple juice uncovered. After service to the residents		All staff have been in-serviced on how to properly handle the passing of drinks during activities and snack times. (10/23/14 & 10/30/14) Part of the education included what a common area is and that the drinks need to be covered and bottle recapped during the passing process in these areas. The volunteer staff have also been educated individually about the proper drinkpassing procedure. All new staff and volunteers will be informed of the process during their orientation. Activities Director, Volunteer Coordinator and Dietary manager will conduct random audits of the process weekly for a month then monthly for at least 6 months on all shifts involved Problems or concerns will be discussed at the Q.A.P.I committee meeting or as needed. The Q.A.P.I committee will monitor for compliance for at least 6 months or as needed Please see following attachments: Exhibit A, Exhibit A-2,Exhibit A-3, and Exhibit E	

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	in the common area, the open tiered snack cart was pushed down the Plum Tree hall room to room. The 46 ounce plastic bottles of apple juice and cranberry juice remained opened and the pre-poured plastic glasses of juice remained un-covered. 2. During an observation on 10/17/14 the following was observed: - At 10:15 a.m., Activities #4 was observed to ask residents seated in the common area if they would like any juice. As a resident requested a glass of juice, she went into the Activity room and poured a glass of juice into a plastic glass. She then was observed to carry the glass of juice into the hallway and common area to serve the resident. The glass of juice was not covered. A total of 7 glasses of juice were served un-covered. 3. During an observation on 10/21/14 the following was observed: - At 9:45 a.m., a facility volunteer was observed pushing an open tiered snack cart through Plum Tree hall. The top tier of the open cart contained a bag of cookies, a covered plastic pitcher of lemonade, and 46 ounce plastic bottles of apple juice, cranberry juice, and grape			

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	juice. The volunteer was observed to push the snack cart from room to room offering residents a snack. The lids of the 46 ounce plastic bottles of juice were removed as residents requested a certain beverage. The lids were not placed back onto the bottles of juice. - At 9:57 a.m., the same snack cart was pushed into the hallway next to the common area where residents were seated and staff were working. The bottles of juice remained opened as residents were served a beverage of their choice. Numerous staff were observed to walk past the opened bottles of juice. - At 10:11 a.m., the volunteer was observed to push the snack cart down Plum Tree hall room to room. The lids were not placed back on the bottles of apple juice, cranberry juice, and grape juice. The Certified Dietary Manager (CDM) was interviewed on 10/21/14 at 2:20 p.m. During the interview she indicated after removing the lid to a bottle of juice and pouring the juice into a glass, the lid should be placed back on the bottle. She also indicated the bottles of juice should not be transported through the halls without the lids on the bottles to protect the juice from contamination. She			

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	further indicated pre-poured glasses of juice should not be transported through the halls uncovered. The CDM was interviewed on 10/21/14 at 3:18 p.m. During the interview she indicated the facility did not have a policy concerning protecting food and beverages from potential contamination. 3.1-21(i)(1)			
F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin			

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review the facility failed to transport clean linens and clean resident clothing in a manner to prevent potential contamination potentially affecting 49 of 63 residents who resided on Cherry and Plum Tree halls. Findings include: 1. During an observation of Cherry Tree hall on 10/15/14 at 11:52 a.m., Laundry #1 was observed carrying a stack of clean resident clothes through the common area and through Cherry Tree hall up against her uniform top. The clothes were not covered and not in a laundry cart. 2. During an observation of Plum Tree hall on 10/15/14 at 12:14 p.m., Laundry #2 was observed pushing an enclosed laundry cart from room to room. She was observed to remove clean resident clothing from the laundry cart. She then	F000441	F441 All residents were identified for potential risk. The laundry staff was educated on a newprocedure on handling, storing and transporting of linens and personal clothingon 10/23/14. All other staff werein-serviced on the new procedure on 10/23/14 & 10/30/14. The Laundry supervisor and Administrator will conduct random audits on all shifts at least once a week for a month, then once a month for at least 6 months or as needed to ensure compliance. Any concerns will be brought up at the Q.A.P.I committee meeting for at least 6 months or as needed. Please see following attachments: Exhibit A, Exhibit A-2, Exhibit A-3, Exhibit F, Exhibit G, Exhibit H, and Exhibit H-1	11/07/2014

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	was observed to place and secure the items on hangers under her arm with the clean clothing pressing against her uniform top and uniform slacks. She was also observed to hold stacks of clean resident clothing up against her uniform top. 3. During an observation on Cherry Tree hall on 10/20/14 at 8:22 a.m., Laundry #2 was observed carrying clean clothing for residents securely under her arm with the clothing pressing against her uniform top and uniform slacks. She was also observed carrying a stack of clean linens up against her uniform top. 4. An observation on 10-15-2014 at 12:27 p.m., indicated Laundry #2 was moving a covered laundry cart from room to room on Plum Tree. Laundry #2 removed the clean resident clothing from the cart and placed the hanging clothes under her arm where the clothes were up against the uniform top and slacks. Further observation indicated Laundry #2 carried a stack of clean clothing in her arms and up against her uniform top and delivered the clean laundry to a resident room. 5. An observation in Plum Tree on 10-15-2014 at 12:34 p.m., indicated Laundry #2 obtained a resident's clean clothes from the laundry cart. Further			

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	observation indicated Laundry #2 carried the resident's clean clothes in her arms and up against her uniform top to a resident's room. Certified Nursing Assistant (CNA) #3 was interviewed on 10/21/14 at 2:55 p.m. During the interview she indicated an enclosed laundry cart was brought to the halls by laundry staff for the CNAs to put away. She also indicated laundry staff put clean clothes away. She further indicated clean linens and clean clothing should be carried away from staff's clothing. The Laundry Supervisor was interviewed on 10/22/14 at 8:23 a.m. During the interview she indicated clean linens and clean resident clothing should not touch staff clothing to protect them from contamination. A current facility policy "Clean Linens - Handling, Storage and Transportation Procedures, revised on February, 2008 and provided by the Director of Nursing on 10/22/14 at 9:15 a.m., indicated "...All clean linens transported through halls by laundry or nursing staff are to be covered...." 3.1-19(g)(1)(2)(3)			

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F000520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility QAA (Quality Assessment and Assurance) Committee failed to implement an adequate action plan for the identified concerns which included but were not limited to the following: infection control regarding linen handling, activities, and significant weight loss. These deficiencies had the potential to affect 63 of 63 residents who resided at the facility.	F000520	F 520 All of the residents with a potential to be affected by this issue have been identified. A new policy for Quality Assurance and Performance Improvement has been written and distributed to all staff. (11/7/14) These changes will incorporate utilizing all staff as a part of our QAPI procedure. On going education in this area will help us continue to improve the Quality of our facility. This program will be ongoing Please see following attachments Exhibit I and Exhibit I-1	11/07/2014

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	Findings include: On 10/22/14 at 9:45 a.m. the DON (Director of Nursing) was interviewed. She indicated the QAA committee included the following members: DON, Administrator, Executive Director, Pharmacy Representative, Medical Director, Residential Coordinator and Staff Development Coordinator. The DON indicated the departments of Activities, Nursing and Dietary relay the QAA concerns to her and she presents their concerns to the QAA committee as the departments of Activities and Dietary were not present at the meetings. The DON indicated they were in the process of changing the QA (Quality Assurance) process by including the actual department leaders in the meeting instead of the DON reporting for them. On 10/22/14 at 10:04 a.m. the DON was interviewed. She indicated she had not been made aware the laundry staff carried clean linens directly against their uniforms. She also indicated she was unaware of the lack of Activities for cognitively impaired residents and/or resident's who experienced weight loss had interventions implemented. On 10/22/14 at 1 p.m. the DON indicated			

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	the QA committed met quarterly and the facility was planning on having smaller QA meetings more frequently. The DON also indicated the QA committee did trend areas of concern to evaluate. The DON indicated she would receive reports and/or concerns from the Activities and/or Dietary Department and would have only looked at items if there was an issue. The DON indicated there have been no concerns with activities and/or that the Activity Department reported to her. Regarding Dietary, the DON indicated they "mention it" but "didn't discuss a lot because (name of Food Service Manager) wasn't involved." She indicated Dietary concerns are discussed more at the NAR (Nutrition At Risk) meetings. The DON indicated through the "old way" they were running the QA meetings, they wouldn't have identified the weight loss as an issue but with the "new way" they will. She indicated with the new way the QA meetings will be conducted, the Activity and Dietary Managers will actually be at the meetings to participate actively. On 10/22/14 at 10:48 a.m. the DON provided a copy of the facility policy and procedure for "Quality Improvement Program." This policy was dated 6/2007 and included but was not limited to, the following: "Continuous Quality			

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	Improvement (CQI) purpose: To identify outcomes resulting from the care and services provided. To use this information to maintain, improve or increase services as necessary...principle mechanism to direct the planned and systemic performance improvement...Efforts are focused on the outcome and will elicit multidisciplinary collaboration...monitors continually the...health care service compliance with the standards of the Indiana State Department of Health and other applicable government agencies...serves as the primary means through which the facility reviews medical/resident/staff recommendations concerning facility procedures and services...QI (Quality Improvement) committee is responsible for overseeing the QI process and activities and in particular:...identify problems relating to care and deficiencies...ensure resident care meets and/or exceeds state and federal regulations...Teams...involved in contributing data for identifying quality issues may include...Falls Team...other sources identifying quality issues are...incident reports...review areas may include but are not limited to...activities...dietetic care...safety issues, housekeeping and laundry services..." 3.1-52(a)(2)			

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R000000	Christian Care Retirement Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R000000		